

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS

10315



رجل الصلوة
RUSAYL HEALTH CENTRE
SAHARA - PAC / RS - PAC

INITIAL EXAMINATION REPORT

Place of examination Date 09/04/19

RS PAC CUNE SAHARA BATTIA

Staff 10315

Home Telephone number 99134888

If a dependant or fiancee entr employees name jere :-

Surname :

Forenames:

Naticnality OMANI

Country of birth OMAN

Religion ISLAM

<input checked="" type="checkbox"/> Male	<input checked="" type="checkbox"/> Single	<input checked="" type="checkbox"/> Widow(er)	Relationship to employee		Number of Children
<input checked="" type="checkbox"/> Female	<input checked="" type="checkbox"/> Married	<input checked="" type="checkbox"/> Divorced Separated	<input checked="" type="checkbox"/> Wife	<input type="checkbox"/> Son	<input checked="" type="checkbox"/> Daughter <input type="checkbox"/> Fiancee 2

Reason for examination Pre-employment

Job :- SUPERVISOR

 Pre-overseas

Area:- BATTIA

Name and address of family doctor

List your last 3 jobs

(1)

(2)

(3)

Are you Registered Disabled Person? (UK) Do you belong to any Medical Insurance Scheme?

DO YOU HAVE OR HAVE YOU HAD :- (Tick 'yes' or 'No' column or put a (?) It ucancelain exclude minor ailmenis.)

	Y	N
1. Sirius rouble		<input checked="" type="checkbox"/>
2. Neck swellings/flands		<input checked="" type="checkbox"/>
3. Difficulty in vision		<input checked="" type="checkbox"/>
4. Any ear discharge	<input checked="" type="checkbox"/>	
5. Asthma/bronchitis	<input checked="" type="checkbox"/>	
6. Hayfever/other allergy	<input checked="" type="checkbox"/>	
7. Any skin trouble	<input checked="" type="checkbox"/>	
8. Tuberculosis	<input checked="" type="checkbox"/>	
9. Shortness of breath	<input checked="" type="checkbox"/>	
10. Coughed/vomited blood	<input checked="" type="checkbox"/>	
11. Severe abdominal pain	<input checked="" type="checkbox"/>	
12. Stomach ulcer	<input checked="" type="checkbox"/>	
13. Recurrent indigestion	<input checked="" type="checkbox"/>	
14. Jaundice or hepatitis	<input checked="" type="checkbox"/>	
15. Gall bladder disease	<input checked="" type="checkbox"/>	
16. Marked change in bowel habits	<input checked="" type="checkbox"/>	
17. Blood in stools (motions)	<input checked="" type="checkbox"/>	
18. Marked change in weight	<input checked="" type="checkbox"/>	
19. Varicose veins	<input checked="" type="checkbox"/>	
20. Lump in breast/armpit	<input checked="" type="checkbox"/>	
21. Cancer	<input checked="" type="checkbox"/>	

	Y	N
22. Heart Disease		<input checked="" type="checkbox"/>
23. Rheumatic Fever		<input checked="" type="checkbox"/>
24. Abnormal heartbeat		<input checked="" type="checkbox"/>
25. High blood pressure		<input checked="" type="checkbox"/>
26. Stroke		<input checked="" type="checkbox"/>
27. Serious chest pain		<input checked="" type="checkbox"/>
28. Any blood disease		<input checked="" type="checkbox"/>
29. Kidney disease		<input checked="" type="checkbox"/>
30. Painful passage of urine		<input checked="" type="checkbox"/>
31. Blood in urine		<input checked="" type="checkbox"/>
32. Diabetes		<input checked="" type="checkbox"/>
33. Headaches /migraine		<input checked="" type="checkbox"/>
34. Dizziness/tainting		<input checked="" type="checkbox"/>
35. Epilepsy		<input checked="" type="checkbox"/>
36. Joints/spinal trouble		<input checked="" type="checkbox"/>
37. Surgical operation		<input checked="" type="checkbox"/>
38. Serious accident /fracture		<input checked="" type="checkbox"/>
39. Tropical disease		<input checked="" type="checkbox"/>
40. Fear of heights		<input checked="" type="checkbox"/>
HAVE YOU EVER BEEN:-		
41. Rejected for employment or insurance for medical reasons		<input checked="" type="checkbox"/>

	Y	N
42. Awarded benifities for Industrial injury/lilness		<input checked="" type="checkbox"/>
43. Treated for a mental condition. eg . depression		<input checked="" type="checkbox"/>
44. Treated for problem drinking or drug abuse		<input checked="" type="checkbox"/>
45. Exposed to toxic substance or noise		<input checked="" type="checkbox"/>
FOR WOMEN ONLY		
Have you ever had:-		
46. An abnormal smear		
47. Any gynaecological treatment		
48. Are you pregnant?		
49. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE ?		

How much tabacco each day ? Non-smoker

Average daily alcohol consuption

Family history	<input checked="" type="checkbox"/> Diabetes	<input checked="" type="checkbox"/> Tuberculosis	<input checked="" type="checkbox"/> Epilepsy	<input checked="" type="checkbox"/> Asthama	<input checked="" type="checkbox"/> Eczerna
Heart disease	<input checked="" type="checkbox"/> High blood pressure	<input checked="" type="checkbox"/> Stroke	<input checked="" type="checkbox"/> Cancer	<input checked="" type="checkbox"/> Blood disease	<input checked="" type="checkbox"/>

PLEASE READ THE FOLLOWING STATEMENT AND IF YOU AGREE KINDLY SIGN IT :-

I declare these statements to be true to the best of my knowledge and belief and I agree that the result of this medical in general terms may be revealed to the company if required, and the details sent to my own doctor if this is considered necessary by the examining medical officer.

Date 09-04-19

Signature of applicant

FOR COMPLETION BY EXAMINING DOCTOR OR SISTER
FURTHER DETAILS OF MEDICAL HISTORY AND RECREATIONAL ACTIVITIES

N - Normal A - Abnormal Please Describe

PHYSICAL EXAMINATION

N	A	
✓		1. Eyes & Pupils
✓		2. E.N.T.
✓		3. Teeth & Mouth
✓		4. Lungs & Chest
✓		5. Cardiovascular System
✓		6. Abdo. Viscera
✓		7. Hermial Orifices
✓		8. Anus & Rectum
✓		9. Genito - urinary
✓		10. Extremities
✓		11. Muscula-skeletal
✓		12. Skin & Varicose Vns.
✓		13. C.N.S.
✓		14. Breasts
		15.

BMI - 27.2 kg/m²
HR - 76 bpm



HEIGHT cm	WEIGHT kg	B.P.	HEARING L R	HEARING L R	VISION: Uncorrected Corrected	DISTANT R L	NEAR R L	COLOUR VISION	BLOOD GROUP
184	92.0	131/85							

LABORATORY AND SPECIAL INVESTIGATIONS

N	A		
✓		1. Urimalysis	
✓		2. Hb Bloodcount ESR	
✓		3. Sarum Profile	
		4. Stool	
		5. E.C.G.	

6. Audiogram
7. Lung Function
8. Chest X-Ray
9. Drug Screen
10. CR Screen

OTHER FINDINGS (physique, scars, disabilities, mental stability etc.)

BMI - 27.2 kg/m²

ASSESSMENT

FIT ALL AREAS FIT HOME SERVICES ONLY UNFIT/UNSUITABLE MAY BE REASSESSED

Date 10.04.19

Signature

MD HASAN MANSOOR RAYZID
MEDICAL OFFICER
RUSAYL HEALTH CENTRE
MOH LIC NO. 15694

Doctor / Sister

REVIEW/CONSULTATION

Date

Signature

Name (Block Capitals)

Doctor / Sister